Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: ALLIED MEDICAL CENTERS P.O. BOX 24809 HOUSTON, TX 77029	MFDR Tracking #: M4-10-5023-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: WORK FIRST CASUALTY CO Box #: 07	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility has sent two status requests and a request for reconsideration, all of which have not been replied to. Therefore does not give us an avenue to properly seek reimbursement for services we provided. This is also in violation of Rule 133.304(a). The request for reconsideration and this MDR are being filed in order to comply with the requirements of **RULE §133.250**(B) and **RULE §133.305.**

Amount in Dispute: $280.00

PART III: RESPONDENT'S POSITION SUMMARY

The Respondent did not submit a position statement.

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
1/4/10	97110-GP-59	54.32 ÷ 36.0791 x $28.82 = $43.39 x 3 units = $130.17	$168.00	$130.17
1/4/10	97112-GP-59	54.32 ÷ 36.0791 x $29.89 = $45.00	$56.00	$45.00
1/4/10	97140-GP-59	54.32 ÷ 36.0791 x $27.01 = $40.67	$56.00	$40.67
			Total Due:	$215.84

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.240 sets out the guidelines for medical payments and denials.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   No explanation of benefits were submitted in this dispute.

Issues

1. Did the insurance carrier pay or deny the bill for date of service 1/4/10?
2. Did the requestor submit proof that the medical bill was submitted to the carrier for processing?
3. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to to rule §133.240(a) An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation. The requestor did not submit any eob's in this dispute. A copy of the requestor's letter of reconsideration to the carrier is submitted along with the bill stating "we have not received either a payment or denial".
2. The requestor has included in this dispute a copy of a fax confirmation sheet dated 2/12/2010 to SRS confirming receipt of the submitted bill. The requestor also submitted a copy of a fax confirmation sheet to SRS dated 4/30/2010 confirming status request of the bill and the requestor also submitted a copy of a fax confirmation sheet to SRS confirming the receipt of a request for reconsideration on 5/20/2010. The requestor has met the burden of proof that the bill was submitted to the carrier on 2/12/2010, 4/30/2010 and 5/20/2010 and the carrier has not responded. In addition, the Respondent did not submit a response to this dispute. Therefore, reimbursement for CPT codes 97110, 97112 and 97140 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $215.84.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $215.84 plus applicable accrued interest per Division rule at 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature	Susan Weber Grist, CPC Medical Fee Dispute Resolution Officer	**11/17/10** Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.